



AAC MYTHS REVEALED

MYTH:

AAC can be provided too soon after a neurological event.

TRUE OR FALSE:

False

What do we mean by “too soon after a neurological event?”

A “neurological event” refers to an incident affecting the brain such as a stroke or brain injury. “Too soon” refers to the time line—hours, days, weeks, months, years.

What do we mean by AAC?

Augmentative and alternative communication (AAC) refers to tools and techniques used individually or in combination to supplement communication for people whose speech is limited or not able to be understood. AAC includes unaided communication techniques (e.g., pointing, gestures), low technology aids (e.g., communication books and boards) and high technology communication devices (e.g., devices and computers that have voice output also known as speech generating devices or SGDs).

What is the expert opinion on the timeline for providing AAC after a neurological event?

AAC can play a significant role in the rehabilitation of an individual following a neurological event. Beukelman, Garrett and Yorkston (2007) wrote,

“Waiting for months to decide whether such individuals will recover enough natural speech and language to communicate is a mistake. Waiting does not serve them as they reassess their priorities in ways that will affect them for the rest of their lives.”

What is the typical timeline for providing AAC after a neurological event?

Let’s follow a hypothetical, but typical, patient named Luke. Use of AAC will keep an individual from talking

- Luke has a stroke or other brain injury.
- Luke is unable to speak during his during his initial hospitalization. He is given a simple communication board containing basic needs. Beyond this board, he is asked many yes/no questions.
- Upon transfer to an inpatient rehabilitation facility, Luke’s communication board remains the same.
- Luke regains some speech but not much beyond a few names, yes, and no. Just before discharge, the communication board is expanded to a book with pages of messages based on categories like meals, places, activities, and basic needs.
- The location of vocabulary in the communication book is targeted first via home health therapy and then in outpatient therapy. Five or six other goals are also targeted.
- Luke abandons his communication book because it is hard to navigate (find what he wants to say in the book) and, when he did find the appropriate page, does not always contain the right messages. Luke communicates primarily via limited natural speech, gestures, and pointing that may or may not be effective. He is often reliant on his communication partner (family, therapist, etc.) to ask the right questions.
- Luke stops making progress in outpatient therapy and is discharged. Over the next six months (or possibly even years), he gains a little more speech but it is not enough to meet his communication needs. Luke is increasingly frustrated.
- Luke’s family searches for other ways to augment communication (such as a communication device). His wife makes an appointment with his old speech-language pathologist.
- Luke’s therapist conducts an AAC evaluation and an augmentative communication device is recommended.

Of course, there are variations of this timeline based on factors such as the degree of speech return an individual experiences, the client’s and family’s willingness to use AAC as a temporary or ongoing means of communication and the speech-language pathologist’s familiarity with AAC.

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What does this timeline infer or assume?

- AAC is a bandage at best and a last resort at worst.
- AAC will interfere with return of speech.
- AAC is not a part of speech therapy.

Let's look at each of these assumptions or inferences.

AAC is a bandage at best and a last resort at worst.

Many people use AAC as if it were a bandage to cover the problem with communication until speech returns. Others present AAC only when all other modes of communication seem to have failed. On the other hand, Fager, Doyle, and Krantounis (2007) indicate we should use AAC from the beginning of the rehabilitation both to foster communication and to address deficits in speech and language skills.

"AAC is an evolving and dynamic process with recovering individuals that complements as well as facilitates treatment. AAC can be an essential tool for treatment as well as a mechanism to bridge the individual into functional communication. It is important to consider AAC as a part of treatment rather than an alternative or last resort" (p. 145).

AAC is a valid form of communication that we all use at various times. Just as it is a part of my communication system and yours, it needs to be part of the communication system of an individual following a neurological event from the start and on an ongoing basis.

AAC will interfere with return of speech.

It is important to state that it is natural and appropriate to desire and work for the return of speech. Individuals who have had neurological events are used to efficiently and effectively communicating through speech. Previously, they have not had to contend with issues like having to work to find the right words, having difficulty with understanding what others say, putting sentences together or getting their mouths to produce words correctly.

However, AAC will not keep the return of natural speech. In fact, research shows that use of AAC can actually facilitate increases in communication and language skills. See DynaVox's Implementation Toolkit resource "Myths—AAC will Keep Someone from Talking" for more detailed information.

Because AAC does not interfere with the return of speech, it can be used along with speech to further enhance communication. The truth is that each of us communicates in multiple different ways. We speak, gesture, make facial expressions and use body language. We point to objects, pictures and signs in the environment, type out messages and write notes.

While we all use forms of AAC in our daily life. The degree to which you and I use it varies depending on the functionality of our speech and the environment. We tend to use AAC more in situations when we shouldn't be talking (at a movie or ceremonial event), when we can't speak (because we are sick) or when we are communicating with a person who does not understand us as well (such as a young child, person who speaks another language).

A person who has experienced a neurological event and subsequent loss of speech will use AAC to a different degree than we do. Just like us, however, they will not use AAC to the exclusion of other forms of communication but along with them. Instead, they will use AAC when it is appropriate, speech when it is appropriate, gesture when it is appropriate and so on. Often these different forms of communication are all used in the same conversation!

AAC is not part of speech therapy.

This inference may be made by individuals when functional use of AAC is not consistently addressed as part of speech therapy. They may not realize that therapy focusing on AAC is language therapy using an alternative or supplemental means of production.

Speech-language pathologists understand that this is part of their scope of practice and the American Speech Language Hearing Association (ASHA) provides information discussing the role of the speech-language pathologist in providing AAC services (<http://www.asha.org/public/speech/disorders/AACSLPbenefits.htm>).

What are the potential results of this timeline for the individual?

In some cases, an individual's speech improves to a point where she is quite functional. However, this does not always occur and, even when it does, it may not occur for a long time. During the time when speech is not functional, we may see:

- Increased frustration with communication on the part of the individual and their communication partners
- Depression and/or withdrawal from social situations
- Resistance to AAC when it is finally presented

How can we improve these results with the support of AAC?

Encourage and model multi-modal communication

Those of us who are interacting with the individual need to encourage use of multi-modal communication by using it ourselves. We need to point to objects and people to supplement speech, use the individual's communication book or board, gesture, and use facial expression and body language. In doing so, we are demonstrating that these methods of communication are valid and useful. We are also providing valuable information about how to communicate with methods other than speech. When referring to AAC, this technique is known as Partner Augmented Input. For more resources on this topic search for "Communication Partner Skills" in DynaVox's Implementation Toolkit.

Use AAC in therapy from the beginning and throughout the treatment process

Scherz (2005) wrote, "**Considering the timing of presenting recommendations for AAC systems, we must present an array of options at multiple times throughout the rehabilitation process.**" Introduction of AAC throughout the treatment process can provide opportunities for successful use, increase an individual's comfort with AAC and decrease the sense that AAC is a last resort.

How can AAC be used in therapy? AAC tools and strategies can be used to work on improving areas of deficit as well as to compensate for them. A rating scale can be used within a typical activity to indicate how difficult it is. Photos in a device or album can be used to share information about family. A communication device can be used to ask questions of the therapist. Functional use of AAC normalizes it and allows individuals to become used to the idea of using tools and strategies.

Because of the positive effect of AAC on language and communication, Ansel and Weinrich (2002) encouraged that "the introduction of AAC principles into aphasia treatment should not be assigned to the final stages of rehabilitation, but rather be incorporated throughout the rehabilitation process." Of course, AAC should be used along with residual speech and other forms of communication.

Dispel the myth that AAC will keep one from speaking

Individuals who have experienced neurological events and those surrounding them often feel significant loss due to changes in social roles and relationships with others. Individuals want to get their speech back for ease and clarity of communication but also as a means to return to previous social roles and relationships. It is important that we dispel the myth that AAC keeps one from talking but also that one cannot return to social roles unless one can speak. DynaVox's Implementation Toolkit discusses "Personal Narratives" to highlight how one can continue to participate socially using AAC.

Remember, introducing AAC early into the rehabilitation process is highly recommended. It has been shown to help provide for both functional communication and participation in treatment activities!

References

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